

**KANSAS FOUNDATION FOR MEDICAL CARE, INC.
PHYSICIAN REVIEWER INFORMATION SHEET
Credentialing Information**

Name: _____ License #: _____
Address: _____ UPIN #: _____
City State Zip: _____ NPI #: _____
Telephone: Office: _____ Home: _____ Fax #: _____
E-mail: _____ Physician Tax ID #: _____

In which of the following specialties are you Board certified? (See attached List B)

If Family Practice, do you deliver (OB)? Yes No Are you a hospitalist? Yes No

Do you have subspecialty certification within the specialties you listed above? (See attached List C)

In which of the specialty or subspecialty areas do you routinely practice?

In which specialties or subspecialties do you want to review?

I certify that I am licensed in Kansas and have active staff privileges* in at least one hospital in Kansas. I am in active practice for at least 20 hours per week.

Yes No **I certify that I care for and treat Medicare beneficiaries in Kansas on a routine basis.**

Signature

Date

**CMS policy defines active staff privileges as a physician who is authorized on a regular, rather than infrequent or courtesy, basis to order the admission of patients to a facility, to perform diagnostic services in a facility, or to care for and treat patients in a facility (See 42 CFR 476.1).*

Please check the box(s) that currently describes your staff privileges:

Active Please list the hospital(s): _____

Courtesy

Provisional

Other: I do not have staff privileges because I currently perform ambulatory surgery procedures in the following outpatient facility(ies): _____